Democratic Republic of the Congo

EOP Summary & Results

Geographic Implementation Areas

Provinces
- 2/26 (8%)—Tshopo and Bas-Uélé

Health zones
- 8/516 (1.5%)—Aketi, Basoko, Buta, Isangi, Yabaondo, Yahisuli, Yakusu, Yaleko

Facilities
- 119/7,144 (2%) community care sites
- 106/8,266 (1%) health centers

Population

Country
- 83.3 million

MCSP-supported areas
- 1.21 million

Technical Areas

Program Dates

January 1, 2015–June 30, 2019

Total Funding through Life of Project

$18,326,485

Demographic and Health Indicators

Indicator	# or %
Population < 15 years old	52%
MMR (per 100,000 live births)	846
IMR (per 1,000 live births)	58
NMR (per 1,000 live births)	28
U5MR (per 1,000 live births)	104
Children <12 months receiving all three polio vaccine doses	62.9%
CPR (modern)	8%
ANC 4+	48%
Facility-based deliveries	80%
Stunting in children < 5 (height for age)	43%
Treatment of diarrhea with ORS	25.4%

Source: DRC DHS 2013/2014.

Strategic Objectives through the Life of Project

- Strengthen the Ministry of Public Health's capacity to strategically scale up cost-effective, evidence-based RMNCAH interventions.
- Improve the capacity of Congolese health professional organizations to provide quality in-service training and PSE on MNH and PPFP.
- In underserved rural communities of Tshopo and Bas-Uélé provinces, improve child survival by supporting IMNCI in health facilities and iCCM; increase the uptake of FP methods through community- and facility-based interventions; and improve the quality of care in health facilities through WASH interventions.

Highlights through the Life of Project

- Contributed to development of national strategies, guidelines, and tools, such as the ENAP, National IMNCI Strategic Plan, National Community Health Plan, and National WASH Standards.
- Launched the Kintambo General Hospital Model Training Center for integrated newborn, maternal, and PPFP care, training, and mentoring.
- From January 2017 to March 2019, treated over 350,000 cases of childhood diarrhea, malaria, or pneumonia, and increased FP and PPFP uptake, with almost 18,000 new FP users initiating services (Figure 1 and 2).
- Piloted approaches to strengthening nutrition services in iCCM in 25 sites and established 25 ilYCF support groups.
- Strengthened data quality and use through DHIS2 trainings in two provinces.
- Scaled up the Clean Clinic Approach and improved WASH in 35 facilities.
- Helped coordinate the national response to the vaccine-derived polio outbreak and assisted with its implementation in six provinces.

Figure 1. New FP acceptors in MCSP-supported areas

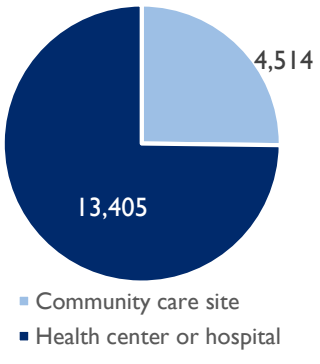
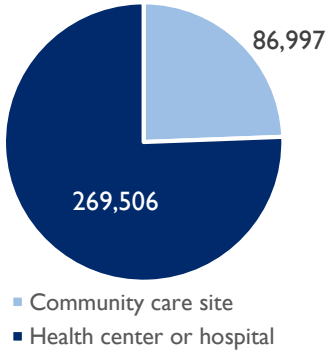


Figure 2. Cases of childhood illness treated in supported areas



Democratic Republic of the Congo

Background

From October 2015 to March 2019, MCSP partnered closely with the Democratic Republic of the Congo (DRC) Ministry of Public Health, USAID, and other stakeholders to improve planning, coordination, monitoring, evaluation, documentation, and scale-up of RMNCAH interventions at the national level and in the two provinces of Tshopo and Bas-Uélé.

Key Accomplishments

Developed National RMNCAH Policy, Strategies, and Tools

In its role as secretariat for the revitalized National RMNCAH Task Force and as technical advisor to the Ministry of Public Health's Division for Family Heath and Special Groups, MCSP supported the development of new national health policies, strategies, and guidelines. Over the life of the program, this included:

- **DRC's ENAP:** Building on the momentum from the Every Newborn Action Forum in Dakar in 2017, in 2018/2019, MCSP supported the Ministry of Public Health to draft and finalize DRC's ENAP and develop a consolidated set of tools for community newborn care. Developed with the WHO, UNICEF, and others, the ENAP tools were subsequently rolled out for use at provincial level by MCSP.
- **IMNCI and iCCM plans, policies, and tools:** With MCSP support, in 2016 and 2017, the Ministry of Public Health updated and approved the National IMNCI Strategic Plan 2018–2022, which included both clinical IMNCI and iCCM components and set ambitious newborn and child health targets. Additionally, in September 2016, MCSP worked with UNICEF and WHO through the Child Health Technical Working Group (TWG) to update DRC's iCCM policy documents and tools. Updated materials incorporated emerging evidence and added visuals to facilitate use by low-literacy CHWs. Others (e.g., Prosani Plus, Save the Children, SANRU-Global Fund) also adopted the revised tools for use in their programs. MCSP also helped develop a new iCCM/IMNCI data dashboard and website to improve monitoring of iCCM scale-up nationally. These tools enable the Ministry of Public Health to track progress in individual community care sites and review human resources and training data across partners and geographies for the first time.
- **National Multisectoral FP Strategic Plan, 2017–2020:** MCSP supported the National Reproductive Health Program to draft the National Multisectoral FP Strategic Plan, 2017–2020, which includes a national FP communications plan and tools to facilitate demand generation.
- **2019–2022 National Community Health Strategic Plan:** In 2018/2019, MCSP played a major role in development of DRC's 2019–2022 National Community Health Strategic Plan, which aims to reinforce community oversight and participation in health. To operationalize the plan, MCSP revised CHW health promotion tools, trained national trainers, and revised a management toolkit; the Ministry of Public Health is now mobilizing resources for additional rollout.
- **Development of annual operational plans:** MCSP supported the Division for Family Heath and Special Groups, the national Acute Respiratory Infection Control Program, and the Cholera and Other Diarrheal Diseases Control Program to develop annual operational plans. The Division for Family Heath and Special Groups costed, for the first time, annual operational plans aligned with the National Health Development Plan in 2017 and 2018, which were used to advocate for resources from partners.
- **Finalization of national WASH standards:** The Ministry of Public Health finalized its national WASH standards in 2018, with support from UNICEF, WHO, and MCSP. Before this, MCSP worked with the Ministry of Public Health to design an assessment tool for monitoring WASH standards in health care facilities and a process referred to as the CCA. Positive results of MCSP's CCA pilot in Tshopo and Bas-Uélé prompted the Ministry of Public Health to adopt the same standards for WASH in health facilities.

MCSP supported rollout of many of these policies and of an earlier set of RMNCAH policies and standard operating procedures that were never fully disseminated. MCSP printed these earlier policies and standard operating procedures and, in June 2017, worked with the Division for Family Heath and Special Groups and

a group of national-level facilitators to train provincial trainers. MCSP partnered with the Tshopo and Bas-Uélé provincial health divisions on a pragmatic training approach for lower levels of the health system that incorporated joint supervision visits and 2 days of regular monitoring and validation meetings, during which provincial trainers introduced the full set of policies and standard operating procedures. MCSP's positive experience with this modified approach was shared with the Ministry of Public Health and partners, many of whom adopted the same strategy with additional provincial health divisions.

Strengthened Congolese Health Professional Associations

In March 2016, the Ministry of Public Health, USAID, and MCSP initiated efforts to strengthen the capacity of three Congolese professional associations that, together, represent the majority of MNH care providers in DRC: the Congolese Association of Pediatricians, the Society of Congolese Midwives, and the Society of Congolese Obstetricians and Gynecologists. Based on results of organizational capacity assessments conducted in 2016, the Congolese Association of Pediatricians was selected to partner with Cuso International under a technical contract with MCSP. Together, the three organizations developed a 5-year (2018–2022) operational plan aimed at strengthening the association's governance, resource mobilization, administration, communication, and advocacy activities. MCSP also supported the Society of Congolese Midwives and the Society of Congolese Obstetricians and Gynecologists for organizational development trainings, technical trainings of trainers, capacity-building in clinical mentorship, and participation in cross-country learning opportunities.

Established a Model Training Center for Integrated Maternal, Newborn, and PPFP Care

In DRC, high newborn, infant, and maternal mortality rates coincide with relatively high reported facility-based delivery rates—approximately 80%, according to the 2013–2014 Demographic and Health Survey (DHS)—indicating a need for improved quality and coverage of care at birth. To improve the quality of integrated MNH/PPFP pre-service and in-service training, in 2017, the Ministry of Public Health and MCSP started work to establish a model training center at Kintambo General Hospital in Kinshasa. Based on an in-depth needs assessment, MCSP, the Ministry of Public Health, and the Kintambo General Hospital's management team jointly developed plans for a state-of-the-art center for pre-service, in-service, and continuing education using the hospital's existing infrastructure.

In April 2019, the Ministry of Public Health formally launched the Kintambo Model Training Center, which now includes a KMC unit, a simulation lab, an FP counseling room, and a training room. MCSP provided materials and equipment for the model training center and completed minor improvements to increase patient privacy and improve the site's organization of services. Using an integrated MNH/PPFP training package, MCSP supported training of a cadre of professional association trainers (23 in total), national Ministry of Public Health trainers, and providers at the model training center using competency-based approaches and peer-to-peer mentoring. Throughout 2018, this cadre cascaded trainings within their institutions and elsewhere in the country, including at the model training center. By September 2018, MCSP had trained 53 of Kintambo's health care providers on the integrated MNH and PPFP package at the model training center. Additionally, the model training center received 150 medical students from the Reverend Kim University who are doing rotations with the maternity department.

A model training center management committee (comprising hospital management and staff) convenes regularly to monitor quality assurance activities and organize pre-service and internship training opportunities with educational institutions. MCSP worked with this committee to develop a sustainability plan and financing policy, and to strengthen quality standards and clinical mentorship systems. Going forward, the model training center will continue to operate under the management committee, guided by the sustainability plan and management tools. Identifying sponsors to fund ongoing activities and facilitate the model training center becoming a national MNH/FP center of excellence is a future priority for the management committee. (For more information, please see the brief and video of the Kintambo Model Training Center.)

Improved Access to and Quality of Child Health Services in Tshopo and Bas-Uélé Provinces

An estimated one out of 10 child deaths in Africa occurs in DRC, with 304,000 deaths in children under 5 reported in 2016.[4] The leading causes of childhood deaths in DRC are neonatal complications, diarrhea, pneumonia, and malaria. Getting high-quality health services closer to remote communities through community-based approaches is a key component of the national strategy to decrease child mortality and morbidity. Introduced in DRC in 2005, the iCCM approach intends to bring lifesaving treatment of childhood illnesses closer to children by training and supporting volunteer CHWs to manage malaria, diarrhea, pneumonia, and malnutrition at community care sites.

In late 2016, MCSP began supporting implementation of the full package of IMNCI and iCCM services in 106 health centers and 119 community care sites in Tshopo and Bas-Uélé provinces that had previously received support for malaria services only. MCSP procured oral rehydration salts (ORS), zinc, and dispersible amoxicillin tablets to be provided free of charge at the iCCM sites. MCSP also trained health care providers and CHWs in IMNCI and iCCM, integrated QI approaches, provided essential supplies and commodities, and supported health worker supervision. Over the life of the program, health centers and community care sites with MCSP support treated over 350,000 cases of childhood malaria, pneumonia, and diarrhea (see Figure 3).

Figure 3. MCSP's impact on child health in DRC

From January 2017 to March 2019, in the 106 MCSP-supported health centers and 119 community sites:

206,704 cases of malaria were treated

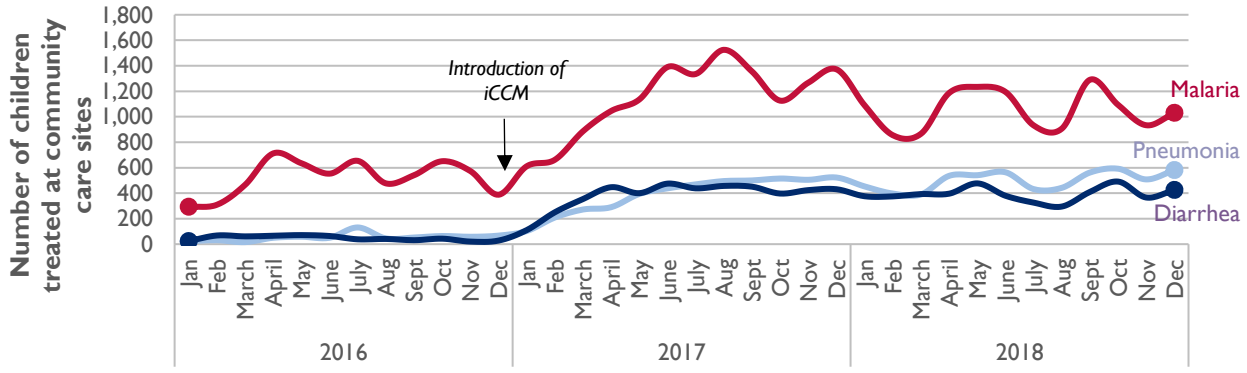
82,387 cases of pneumonia were treated

67,412 cases of diarrhea were treated

Based on analysis of health centers and community sites with a minimal threshold of complete reporting into the DHIS2 from 2016–2018, the number of cases of childhood diarrhea and pneumonia treated increased more than four times between 2016 and 2018 at the facility level and eightfold at the community level (Figure 4). This demonstrates that introduction of an integrated package and provision of free drugs can substantially increase the number of cases of child illnesses treated at all levels, including in underserved communities. (For additional information, please see the infographic.)

Figure 4. Trends in treatment of child illness in the community and health centers before and after introduction of iCCM and IMNCI in Bas-Uélé and Tshopo (2016-2018)

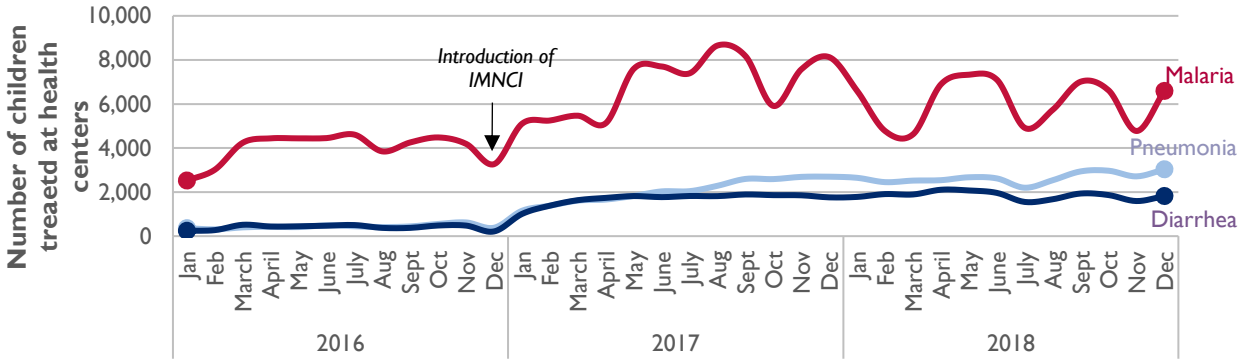
4a. Increases in treatment of child illness at community care sites in Tshopo (n = 37) and Bas-Uélé (n = 17) provinces*



*Data shown only for sites with minimum threshold of complete reporting in 2016.

[4] UNICEF, WHO, World Bank Group, United Nations. 2017. *Levels and Trends in Child Mortality Report 2017*. New York City: UNICEF.

4b. Increases in treatment of child illness at health centers in Tshopo (n = 79) and Bas-Uélé (n = 27) provinces*



*Data shown only for sites with minimum threshold of complete reporting in 2016.

Strengthened Nutrition Services for Women and Children

In DRC, 43% of children under 5 suffered from stunting, 8% were wasted, and 23% were underweight at the time of the 2013/2014 Demographic and Health Survey. In response, the Ministry of Public Health, DRC's national nutrition program, and MCSP prioritized the strengthening of nutrition-related strategies within iCCM and IMNCI. This was in recognition of the fact that the standard nutrition component of iCCM was limited to identification and referral of children with severe acute malnutrition and did not include preventive aspects of nutrition (e.g., improving IYCF practices around breastfeeding and complementary feeding, and building CHW IYCF counseling skills).

With MCSP support, DRC's national nutrition program undertook a formative study to guide integration of nutrition within iCCM. The study's findings informed the design and implementation of a pilot that involved 25 pairs of community care sites and health centers in three health zones in Tshopo Province. As part of the pilot, MCSP supported strengthening of existing IYCF-focused mothers' support groups and the creation of new groups in communities where they did not exist. Within these groups, caregivers were counseled to improve care seeking for sick and/or malnourished children, exclusively breastfeed their infants, and adopt healthy complementary feeding practices. By the end of 2018, 19 of 25 groups were fully active. Study findings were also presented during the 2018 Accra *Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child* workshop, during which the country delegation prioritized gaps and developed a country action plan to strengthen the capacity of CHW to strengthen nutrition aspects of the iCCM strategy.

Also based on the study's findings, MCSP supported the review and adaptation of existing Ministry of Public Health IYCF counseling cards and facilitated provincial and health zone teams to train facility-based providers and CHWs. In the pilot areas, by the end of 2018, 2,455 sick children under 5 years old had been screened in the community for malnutrition, and 795 pregnant women and 980 caretakers with children under age 2 had received nutrition counseling. In the future implementation of this approach, it will be critical to continue the strengthening of provider capacity to provide quality IYCF counseling, coupled with supportive supervision efforts. DRC's national nutrition program has expressed interest in continuing these efforts.

Improved Access to FP Services at Community and Health Facility Levels

According to the 2013/14 Demographic and Health Survey, DRC has the third highest fertility rate globally, at 6.6 children per woman, a national MMR of 846 per 100,000 live births, and an adolescent birth rate of 138 live births per 1,000 adolescent women. FP can support reductions in maternal mortality by 30–40%, but in 2013, the contraceptive prevalence in the DRC was just 8%, and there was a high rate (28%) of unmet FP need. This was attributed to poor integration of FP within the package of services offered at the health facility level, stock-outs of contraceptive commodities or supplies needed for service delivery, limited availability of health services that specifically target adolescents and young adults, and inadequate recruitment, deployment, and geographic distribution of community-based distributors able to reach clients where they live.

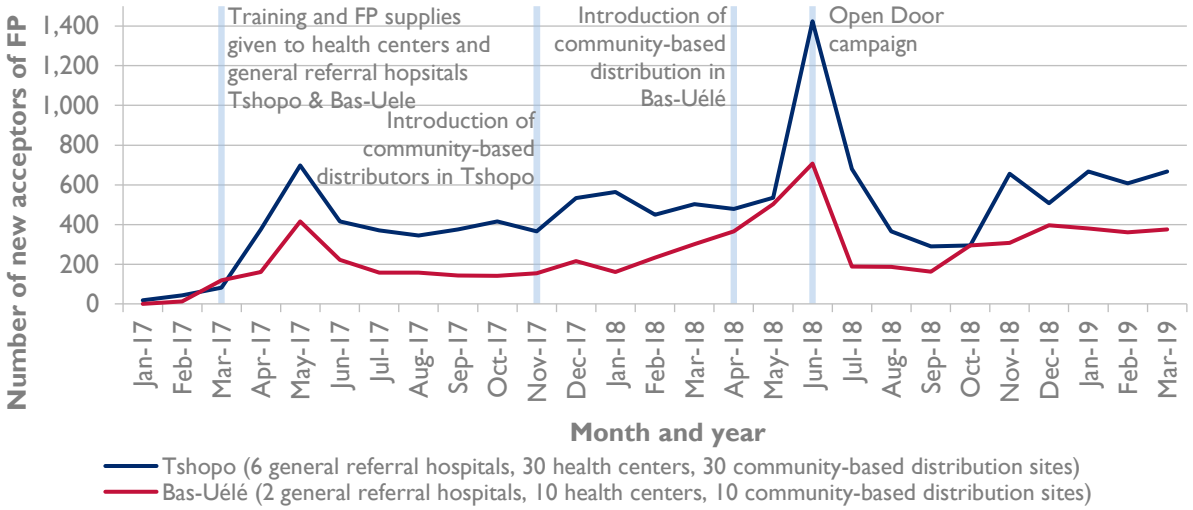
MCSP partnered with the Ministry of Public Health's provincial health divisions in Tshopo and Bas-Uélé to improve access to FP/PPFP services and increase voluntary uptake in underserved, rural communities. In line with the Ministry of Public Health's National Reproductive Health Program, MCSP and the two provincial health divisions worked to:

- Establish quality FP/PPFP services within existing health infrastructure by providing training, supervision, and the distribution of equipment, commodities, and tools.
- Garner interest and demand at the community level through interpersonal communication and promotional activities, such as radio broadcasts.
- Conduct three "Clinic Open Door" campaigns in 2018 to encourage women and community members to visit facilities where FP education and other services were offered free of charge.
- Develop a formal, national-level FP communication plan for replication at the health zone level that integrated PPFP messaging into antenatal, delivery, postnatal, and extended postpartum care.

Over the life of the program, MCSP's FP/PPFP activities in Tshopo and Bas-Uélé provinces reached eight health zones, eight general hospitals, 40 health centers, 40 community care sites, and 85,000 women of reproductive age. At community level, MCSP's approach relied upon community-based distributors to facilitate client access to FP information and services, improve awareness, generate demand, and provide clients with short-term contraceptive methods. Throughout 2017–2018, the Ministry of Public Health and MCSP supported provincial trainers to train 120 community-based distributors in the eight health zones. By December 2018, each of the 40 community care sites had three distributors in place.

The addition of FP/PPFP services at health centers and general referral hospitals in Tshopo and Bas-Uélé contributed to increased numbers of new FP acceptors between 2017 and 2018. At the community level, community-based distributors and Clinic Open Door campaigns supported further increases in new acceptors (Figure 5), indicating the effectiveness of community-based interventions in increasing voluntary FP uptake. (Additional details can be found here.)

Figure 5. Number of new FP acceptors by implementation site



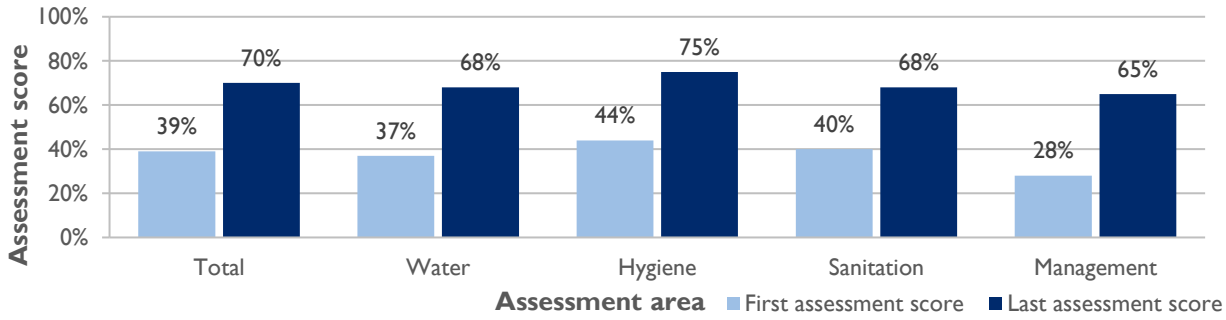
Implemented WASH CCA

DRC's 2014 Service Availability and Readiness Assessment showed that nationally, 63% and 59% of health care facilities lacked an improved water source and improved sanitation facilities, respectively. At the start of MCSP, only six of 15 (40%) of MCSP-assisted facilities in Bas-Uélé and three of 20 (15%) of supported facilities in Tshopo had access to water at least 5 days a week. With facilities unable to ensure provision of safe, high-quality, and trustworthy services, MCSP implemented the CCA to help them meet national WASH standards.

MCSP piloted CCA in 10 facilities in Bas-Uélé and Tshopo in August 2016 and scaled it to 25 more facilities in October 2017. CCA activities included assessing facilities; training providers, facility cleaners/hygienists, and CHWs; establishing hygiene committees at each facility and community feedback mechanisms; integrating WASH into broader facility-based action plans; supporting quarterly visits to each facility by district health inspectors; documenting results; and recognizing achievements. After a year, the 35 facilities increased average CCA scores from 39% to 70% between their first and last assessments. Among four technical areas, facilities scored highest in hygiene at final assessment but improved most substantially in WASH management, with the average facility score increasing from 28% to 65% (Figure 6).

WASH improvements brought increased user confidence, especially among pregnant women who had been afraid to deliver in unclean facilities that lacked water. There were also reported increases in attendance for preventive and promotional care, including ANC and RI. At the Lilanda health facility in Tshopo, for example, the number of facility births reportedly quadrupled over 5 months, with clients citing improved WASH services as the motivation for delivering at the health center. In Tshopo, the five facilities reaching Clean Clinic status saw their patient intake and the number of deliveries double from 166 to 333 patients and from 12 to 26 deliveries, respectively. As a result, income to these facilities nearly tripled during this period, from CDF 262,000 to 738,000, which facilities reinvested in health care services. The Ministry of Public Health has now adopted the CCA (integrating lessons from a separate UNICEF WASH activity into this intervention) and is expanding implementation to other regions.

Figure 6. Average start and end CCA assessment scores (n = 35 facilities in Bas-Uélé and Tshopo)



Improved Data Quality and Use

MCSP supported DHIS2 software trainings for data managers and zonal medical officers from MCSP-supported zones in Tshopo and Bas-Uélé provinces. The aim was to improve the quality, management, analysis, and use of data collected by health facilities and CHWs, and uploaded to the DHIS2 platform. MCSP ensured that data collection tools were available in the health zones, supported provincial data analysis meetings, introduced standardized "dashboards" in health facilities and at community care sites, and conducted joint data quality assessment visits with Provincial Health Division staff to health facilities. All of these activities positively affected the availability and quality of service data. MCSP's legacy is a strengthened health information management system (HMIS) in program-supported health zones, facilities, and communities.

Coordinated with Partners to Respond to Polio Outbreak

From January 2017 through March 2019, DRC had 45 confirmed cases of circulating poliovirus derived from the type 2 vaccine strain in seven provinces. From June 2017 to October 2018, the Ministry of Public Health Polio Emergency Operations Committee conducted 11 supplemental geographically focused immunization campaigns as part of the outbreak response, with the support of partners including WHO, UNICEF, USAID, the Bill & Melinda Gates Foundation, and the US Centers for Disease Control and Prevention (CDC).

MCSP provided technical assistance and helped coordinate the polio response at national level, and deployed seven senior consultants to assist with implementation of the outbreak response and supplemental

immunization activities in six provinces. These technical experts worked closely with the Ministry of Public Health and other partners to coordinate and plan an effective response, train supervisors, support vaccine stock management, enhance communication with local authorities and community members, and contribute to M&E. Technical support provided by MCSP consultants, plus their continuous mentoring and supervision of field staff, brought new levels of skills, competence, and innovation to engage and build trust among communities and noncompliant households. MCSP consultants used the campaigns to reinforce the RI system and use of real-time data, roll out the new surveillance guidelines, and address rumors related to polio vaccine uptake, often by working with religious and community leaders. The circulating poliovirus derived from the type 2 vaccine strain outbreaks appeared to be slowing in early 2019, when MCSP closed out. The only way to prevent them in the future is to ensure that polio vaccination rates stay at 80% or higher in all provinces, at all times.

Recommendations for the Future

Based on its experience at the national level and in Tshopo and Bas-Uélé provinces, MCSP has the following recommendations for future donors and implementing partners in DRC.

- **Continue and expand the integrated IMNCI/iCCM, FP/PPFP, nutrition, and WASH approach that MCSP demonstrated in Tshopo and Bas-Uélé provinces.** As of June 2019, MCSP had engaged in discussions with UNICEF, Enabel, SANRU, Medecins Sans Frontieres, and the Ministry of Public Health provincial health authorities to advocate for continued implementation of the full package of IMNCI/iCCM, FP, WASH, and nutrition services in these two provinces.
- **Ensure DRC's policies and other national-level documents are up-to-date, evidence-based, and effectively implemented.** At the national level, continued investments are needed to support the Ministry of Public Health's RMNCAH policy agenda. Future donor support will help the ministry and its partners to ensure that the country's policies, strategies, and guidelines are evidence-based; that implementation incorporates global best practices; and that needed resources are identified, communicated, and mobilized.
- **Continue to support the RMNCAH Platform and its working groups to inform national policies and plans, including those related to the Global Financing Facility Investment Case.** MCSP helped strengthen the coordination and leadership capacity of the Ministry of Public Health Division for Family Heath and Special Groups and revitalized the RMNCAH task force, which had not met for a number of years before 2016. In June 2018, the honorable minister of health elevated the RMNCAH task force, renaming it the RMNCAH Platform, developing new terms of reference, and putting it directly under his own purview. Although this bodes well for the government's future RMNCAH commitments, MCSP's work with the more agile TWGs and programs led to more than 50 national policy and strategy changes.
- **Support the Ministry of Public Health's planned iCCM scale-up and advocate with other donors and with the government itself to match needs with resources.** USAID support for the full iCCM package and approval for commodities procurement was vital to successful implementation. To bridge the large gap between DRC's evidence-based policies and plans and their implementation, resources must be available to roll out new policies and strategies once developed. Donor investments and national budget allocations should be better aligned so that both are consistent with national policies and plans.
- **Continue supporting the model training center to ensure it becomes fully sustainable.** The Kintambo Model Training Center institutionalizes competency-based training and demonstrates a promising approach for the future. The integrated MNH/PPFP training tools, which were developed and approved by the Ministry of Public Health, are ready to be used in replicating this approach in other provinces. The model training center's governing mechanism and sustainability plan will also require continued support.
- **Follow the national iCCM and community health strategies.** This should include procurement of commodities and targeted advocacy to increase government purchase of these commodities. In Bas-Uélé and Tshopo provinces, MCSP built its iCCM, nutrition and FP work on a platform of community care sites that offered only malaria services. The geographic coverage of these sites was limited, and it was not possible to increase their numbers with available resources. MCSP was only able to expand the iCCM

package in existing sites to include pneumonia and diarrhea by making amoxicillin, ORS, and zinc available. Donated nutrition and FP commodities made it possible to offer these services in a subset of communities. Without greater geographic coverage and guaranteed access to commodities, the impact of IMNCI/iCCM and other integrated service delivery strategies will continue to be limited.

- **Advocate to other donors and the national government to continue growing FP/PPFP services in Tshopo and Bas-Uélé, though they are no longer priority provinces for the Mission.** FP was not among MCSP's original objectives, but in 2016, when USAID made a shipment of donated contraceptives available to Tshopo and Bas-Uélé, MCSP saw an opportunity to add FP and PPFP capacity-building to its support. The need was obvious—there were almost no FP services available in the provinces, and provider and client uptake was steady over the life of the program.
- **Provide necessary resources to operationalize the national HMIS and build on MCSP's work to ensure data quality and use will continue.** MCSP strengthened infrastructure and systems and built government capacity to operationalize the national HMIS and use routine data at the community, facility, and health zone levels in the two provinces of Tshopo and Bas-Uélé. Continued support for the infrastructure and systems—such as provision of paper forms, internet credit for data entry into DHIS2, and technical and financial support for data review meetings, data quality audits, and improvement plans—will be needed to ensure that gains are sustained and scaled up to all health zones in the two provinces.

Select Performance Indicators for Life of Project	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Number of (national) policies drafted with USG (MCSP) support	17[5] (target: 9; target exceeded)
Number of people trained through USG-supported programs	3,072 (target: 3,899; 79% achieved)
Number of children under age 5 with fever, diarrhea, and/or fast/difficult breathing for whom advice or treatment was sought from a facility or community case management-trained CHWs in MCSP-supported areas	450,639 (target: 361,103; target exceeded)
Number of cases of child diarrhea treated in USAID-assisted (MCSP) programs	67,412 (target: 63,766; target exceeded)
Number of cases of child pneumonia treated with antibiotics by trained facility or CHWs in USG (MCSP)-supported programs	82,387 (target: 66,125; target exceeded)
Percent of children ages 0–59 months in malaria-endemic areas presenting with fever who were tested with rapid diagnostic test or microscopy	93% (target: 100%; 93% achieved)
Percent of confirmed malaria cases in children ages 0–59 months who receive first-line antimalarial treatment	93% (target: 100%; 93% achieved)
Number of women initiating FP services (new users) at facilities or from trained CHWs in MCSP-supported areas	17,919 (target: 18,035; 99% achieved)
Percentage of target health facilities in MCSP-supported areas with handwashing stations and appropriate handwashing supplies available to the maternity and/or surgery wards or units (both if they exist)	100% (target: 100%; target achieved)

For a list of technical products developed by MCSP related to this country, please click here.

[5] Updated iCCM and IMNCI guidelines and tools (2); PPFP Package (1); Modules & technical briefs for Integrated packages for care on the day of birth and the immediate postnatal period adopted, including HBB, day of birth, bleeding after birth, and PPFP (7); 14 modules Primary Health Care management package (1); IMCI/child health strategic plan (1); FP communication modules and guidance (1); CCA training modules (1) and M&E tools (1); promotion of key family practices modules (1); National guidelines for WASH in health care facilities (1); National Community Health Strategy (1)